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ABSTRACT

This recommendation urges the governments of countries belonging to the Council of Europe to adopt a comprehensive policy for health education in schools. An appendix to the recommendation defines health and health education, states objectives of school health education from the preprimary to secondary levels, offers guidelines for the planning and development of a health education program, points out the importance of research and curriculum evaluation, emphasizes that all teachers need to be prepared for working in the field of health education, lists objectives to be pursued in the preparation of teachers for health education, promotes a multidisciplinary approach to teacher training, and advocates development of policies to ensure coordination between health and education sectors. An explanatory memorandum provides a rationale for each section of the appendix. A table provides an outline of the developmental approach to health education for school-age children in the areas of physical, social, and mental and emotional development. (JDD)

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School health education and the role and training of teachers

Recommendation No. R (88) 7
adopted by the Committee of Ministers
of the Council of Europe
on 18 April 1988
and
explanatory memorandum

Strasbourg 1989

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RECOMMENDATION No. R (88) 7 OF THE COMMITTEE OF MINISTERS TO MEMBER STATES ON SCHOOL HEALTH EDUCATION AND THE ROLE AND TRAINING OF TEACHERS

(Adopted by the Committee of Ministers on 18 April 1988 at the 416th meeting of the Ministers' Deputies)

The Committee of Ministers, under the terms of Article 15.*b* of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is to achieve a greater unity between its members and that this aim may be pursued, *inter alia*, by the adoption of a common approach in the health and social protection fields;

Recalling its Recommendation No. R (82) 4 on the prevention of alcohol-related problems especially among young people and its Recommendation No. R (82) 5 concerning the prevention of drug dependence and the special role of education for health, as well as the concerns which lay behind these two recommendations;

Considering that, in spite of the development of elaborate and specialised health systems combining general preventive measures and the availability of medical care services, numerous health problems continue to arise which do not respond to traditional preventive and curative measures;

Noting that the majority of these problems are linked to life-styles not conducive to health and that health education can contribute to avoiding them by promoting healthy attitudes and life-styles;

Noting that, alongside the central role of the family, the most appropriate structure for the introduction of health education is the school, as it regroups the young, the age-group which is most able to learn healthy behavioural patterns;

Conscious that the establishment of school health education programmes requires:

— guidelines for the planning and development of health education curricula;

— a clear definition of the role of the teacher in this field;

— basic, in-service and further training of all teachers to allow them to contribute within their field to the programmes in question,

Recommends that the governments of member states adopt a comprehensive policy for health education in schools, taking into account the matters contained in the appendix.

Appendix to Recommendation No. R (88) 7

1. *Basic concepts*

1.1. Health is more than the absence of infirmity or illness, it is a quality of life comprising social, mental, moral and emotional as well as physical dimensions. It is a dynamic asset to be acquired, defended and constantly rebuilt throughout life.

1.2. Health education essentially consists in:

— providing better information on factors which influence health,

— elucidating the relationships which exist between health and the physical and psycho-social environment,

— developing individual, family and collective awareness and a sense of responsibility in relation to health,

— promoting responsible attitudes and ways of life conducive to health.

1.3. Health education at school implies that children and adolescents are confronted with formal and informal experiences enabling them to acquire attitudes and behaviour patterns which have a positive effect on their health, and are given the information and capacities required in order to make free decisions. It is different from other "taught" school subjects in that it is an interdisciplinary activity which has to permeate the whole of school life and extend into the outside community, and requires a personal commitment on the part of all those involved.

2. *Objectives of school health education*

School health education should:

i. at pre-primary level, promote the mental, social and emotional development of children within the pre-school environment, stimulating

them to become aware of their bodies in relation to others and the environment; and encourage experience of, and active participation in, the decision-making process;

ii. at primary level, allow pupils gradually to acquire knowledge of human growth and development, and awareness of the basic issues of the relationship between health and the environment;

iii. at secondary level, enable young people to develop their knowledge of human growth and of physical, psychological and social development, and of factors which have a positive or negative effect on health; to appreciate positively this period of physical and psychological change to attain a proper measure of self-esteem; to learn to analyse attitudes and behaviour which have an effect on health, in order to facilitate active training in decision-taking.

3. *Guidelines for the planning and development of a health education programme*

3.1. Health education programmes should take account of school-children's social and cultural environment.

3.2. Programme planners should take account of:

i. state of health needs and health-related behaviour as identified by children and young people themselves, and by their parents;

ii. state of health needs, as identified by doctors, practitioners and health inspectors;

iii. the state of health needs and types of health-related behaviour as they are seen by the community in which the children and young people live and by that in which they might later live.

3.3. Through a participative process, planners should develop a school health programme reflecting identified needs and priorities. School health education programmes should be articulated on three levels:

3.3.1. The health-promoting curriculum, including an overt "taught" component and different approaches incorporated in all aspects of the curriculum;

3.3.2. The ethos established at school or health in school. It is necessary to ensure that life within the school is consistent with the aims of the health education programme; it should ensure physical and mental health and good social relations;

3.3.3. The various provisions of the school health and social services. Good co-ordination between the school and health and social services is necessary just as much to ensure the involvement of these services in the development of school health education programmes as in their implementation.

3.4. The health-promoting curriculum should take account of changes and developments occurring within the school population and its environment.

3.5. Health education issues should be taken up repeatedly at different levels of increasing complexity, according to the level of understanding of children and young people, so that they relate to their interests and needs (spiral development of curriculum).

3.6. As the objectives range from imparting knowledge to modifying behaviour, all methods might be considered, from the most classical to the most modern: traditional classes, discussion, group work, socio-educational activities, communication techniques, etc. Whatever methods are adopted, their effectiveness is influenced by the involvement and degree of commitment of the teacher.

4. *Research and evaluation*

4.1. Research could give a better understanding of the perceptions of pupils, teachers, parents, social services and health service staff and representatives of the community with regard to health, and could help in the development of teaching materials designed to improve working conditions in the classroom and taking account of the most recent scientific data.

4.2. All components of the curriculum should be evaluated and the achievement of objectives assessed in a formative and summative way; teachers, pupils, parents, social and health service staff, and community representatives should all be involved in this process.

5. *Training of teachers*

5.1. In view of its differences from other "taught" subjects, all teachers need to be prepared for working in the field of health education, whether they are to play a major or a minor role.

5.2. Teacher training should be organised for primary school teachers preferably at both initial training and in-service levels. Secondary school teachers should be introduced to health education during their basic training, and should have the opportunity to extend their knowledge during the course of their work.

6. *Professional preparation of teachers*

6.1. In general, teachers should be:

i. familiar with current theoretical bases of health education;

ii. aware of national developments in the field both within the educational system and in the community at large.

6.2. During training, the following issues should be stressed:

i. the potential of the school as a forum for promoting the health of children individually and the "collective" health of the school community;

ii. health education is not only concerned with giving information but involves the clarification of values, attitudes and beliefs with a possibility of multiple choice and is not free from ethical considerations;

iii. health is multi-faceted and is influenced by decisions taken and policies adopted in a wide range of government sectors (for example health, social and economic fields);

iv. health education needs to be seen as a democratic process where pupils are encouraged to seek out and use relevant information leading to appropriate decision-making in given situations.

6.3. Objectives to be pursued in the preparation of teachers for health education should include the following:

i. increasing knowledge about health; this should include social, emotional, moral and mental as well as physical components;

ii. increasing understanding of the relationships between health and other components of the curriculum;

iii. helping teachers and students to see that health education is an essential element in the development of personal skills and the personality;

iv. demonstrating that health issues can be integrated into other aspects of the curriculum;

v. demonstrating the importance of a variety of informal approaches which should be congruent with the formal health education curriculum;

vi. helping teachers and students learn the use of methods appropriate to health education;

vii. helping teachers recognise the role of others in education for health and of pupil counselling; they should be encouraged to call upon the expertise of teaching colleagues, members of the school health service, community groups, parents, etc.

6.4. The contents of training should ensure that all teachers, in the course of their professional preparation:

i. acquire a basic knowledge about and a sense of responsibility for creating a healthy school environment;

ii. be made sensitive to the health needs of children;

iii. obtain an insight into the basic growth and developmental processes of children;

iv. acquire knowledge of the skills necessary to make independent decisions about one's own health;

v. become familiar with the methodology to be used relevant to the cognitive and emotional elements of curriculum development;

vi. become skilled in multidisciplinary work with colleagues in collaborative teaching strategies;

vii. become able to co-operate with other significant individuals, systems and services.

6.5. Teachers who are identified as having specific roles in the school health education programmes, for example, co-ordinators, those involved in teaching particular parts of the curriculum or particular groups of children, need to have appropriate skills in addition to those of other teachers. They should be familiar with all aspects of the curriculum related to health. They should, in particular:

i. have special knowledge of how to develop comprehensive programmes and how to identify possible gaps;

ii. play appropriate roles in implementing the programme;

iii. be able to give advice to other teachers; and

iv. assess the achievement of objectives, evaluate both the appropriateness of the methods employed and the effectiveness of the curriculum in contributing to pupils' health.

7. Organisation of teacher training

7.1. Training colleges and other appropriate establishments, should gradually become organised in order to provide this type of training for teachers through multidisciplinary teams; in the absence of specialists, such colleges should appoint a co-ordinator to enlist specialists from a variety of disciplines from outside the college to ensure that the eclectic nature of health education is reflected in the teaching.

7.2. In-service training should be organised, preferably within the school, by co-ordinators belonging to the above institutions.

7.3 Training institutions responsible for the pre-service and in-service training of teachers should have at their disposal guidelines in the form of training documents which should be prepared at national level through co-operation between the health and education sectors. Such documents should contain:

i. a guide to the training including both method and content;

ii. all the necessary materials for teachers participating in the course.

7.4. In-service training should include examination of topical questions.

8. *Development of policies on health education*

8.1. In order to ensure impact throughout the school system, policies need to be developed. Such policies should:

i. ensure co-ordination at central, regional and local levels between the health and education sectors by means of co-ordinating committees supporting the introduction of health education in all school curricula;

ii. provide for the appointment of persons responsible at regional level for developing strategies within schools in close co-operation with the head teacher and, if necessary, the school co-ordinating committee;

iii. ensure that resources of time and materials are provided to support all those involved.

EXPLANATORY MEMORANDUM

Introduction

The increase in health expenditure in the community calls for a careful assessment of the health care strategies hitherto employed.

Numerous recent measures adopted by the member states within their health care policy reflect this concern. One of the prominent features of recent policy reorientation in Europe is the shift of emphasis from curative to preventive medicine and education for health.

In 1981, the Madrid Conference of European Health Ministers, when examining strategic issues in relation to prevention and education for health, agreed that school health education was a major issue for the decade ahead. In particular it agreed that:

— there was a need to replan the approach to health education which implied giving it a new positive multidisciplinary and "de-medicalised" dimension;

— there was a need for children to know how to choose their way of life wisely in order to prepare them to realise their individual and collective development;

— proper teacher training was of the highest importance for the success of health education in schools.

An inquiry carried out by the select committee throughout member states confirmed that there was a consensus as to the general concepts and approaches relative to health education; it also showed, however, that countries have reached different stages of implementation, that methods vary greatly and that gaps persist in the absence of a comprehensive national policy co-ordinating the health and education sectors.

Pursuing co-operation throughout Europe in both fields, the Council of Europe appeared to be the most appropriate body to carry out a study covering all aspects of the introduction of health education in schools:

— its place within school curricula,

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— curriculum development,
— teacher training,
— co-operation with the health sector,
— policy-making.

Accordingly, a joint select committee of experts was appointed by the European Health Committee (CDSP) and the Council for Cultural Co-operation (CDCC) including experts in health, health education and education.

For the purposes of the Recommendation and the explanatory memorandum the following basic concepts were agreed upon:

1. Basic concepts

1.1. The WHO definition was taken as the starting-point, although it was recognised that health is difficult to define. However, all those who have tried to do so agree that it is more than the absence of infirmity or illness; it is a quality of life comprising social, mental, moral and emotional as well as physical dimensions. It is a dynamic asset to be acquired, defended and constantly rebuilt throughout life.

Fundamentally, health is the ability to adapt to change whether physical, social or psychological. But it is more than that. It also includes the idea of dynamic interaction between the individual and his entourage and environment and even the idea of a full development of the physical, mental and social potential of the individual.

1.2. As indicated in the Recommendation, health education essentially consists in:

— providing better information on factors which influence health;

— elucidating the relationships which exist between health and the physical and psychosocial environment;

— developing individual, family and collective awareness and a sense of responsibility in relation to health;

— promoting responsible attitudes and ways of life conducive to health.

As such, health education is of concern to all age-groups; it is part of continuous education which, in our societies, has become an essential objective for the whole population. The integration of health education in this active process will hopefully make it possible to promote cultural changes in relation to health.

Within the general population, it is admitted that young schoolchildren seem to be the age-group which could most easily adapt and respond to these changes. This explains the priority given by the Council of Europe to the drafting of a recommendation dealing specifically with school health education.

1.3. School health education implies that children and adolescents should be confronted with formal and informal experiences enabling them to acquire attitudes and behaviour patterns which have a positive effect on their health, as well as the information and capacities required for making free decisions.

Historically, health education has been variously interpreted: originally, it essentially took the form of health instruction, with an informative and didactic approach; later, emphasis was placed on health care and advice; at present the tendency is to consider health education as a fundamentally educational process and emphasis is placed on the need to produce healthy attitudes and behaviour based on adequate knowledge.

An important aspect of this new concept from the methodological angle is that pupils and adolescents have to be encouraged to explore their own attitudes and convictions, clarify values and finally analyse the various steps in the decision-making process. The result of this development is that health education is more than a subject to be taught; this goes a long way towards explaining the difficulties so far encountered by teachers in putting it into practice.

It is worth mentioning in this connection, the main characteristics of health education at school. As said in the Recommendation, health education is different from other "taught" school subjects for a variety of reasons:

— it is a basic element of the comprehensive education of the individual;

— it has not only cognitive, but also important emotional and behavioural components;

— it is a theme which runs through all school subjects;

— it has all-embracing characteristics calling for interdisciplinary co-operation and shared responsibility (pupils, parents, the school teaching team as a whole, social and health staff and other representatives of the community);

— it requires deep knowledge of the social, cultural and economic background of the group represented at school;

— it requires a personal commitment on the part of all those involved;

— it includes several distinct elements both formal and informal which all have to be built up into a coherent programme.

In the field of school health education, three complementary curricula are to be considered:

— the taught or formal curriculum, which includes knowledge concerning the various factors influencing health;

— the informal curriculum, also called the "school ethos", consists of the various messages which are conveyed to pupils through their daily school experience, which are likely to influence their health-related behaviour;

— the parallel curriculum, which relates to the various values and beliefs conveyed by the family, clubs and the community in general.

The educational process in question accordingly not only involves the school community and in particular its teachers and health and social services, but also the philosophy and general life-styles it promotes; it extends into the outside community and should be carefully co-ordinated with the local health and social policy. As already pointed out by other Council of Europe publications in this field, for health education to be effective and efficient, it is crucial to ensure its integration within all aspects of the school curriculum and daily life, and to ensure that messages are consistent with and reinforce the "outside" local policy.

2. Objectives of school health education at the pre-school, primary and secondary levels

2.1. The following objectives apply to three broad age-groups; they should be adapted to the group's verified knowledge and needs and developed through a "spiral" curriculum. This process should take account, as much as possible, of the environment, of the socio-cultural background in which these age-groups live and of its continuous changes.

i. *At the pre-school level*

Health education should enable children gradually to:

— become aware of their abilities through a series of positive experiences;

— develop positive relationships with others involving emotional experiences;

— become aware of their bodies, in relation to others and the environment with a view to acquiring control of it;

— become acquainted with risk and its control;

— encourage experience of, and active participation in decision-making.

Methodology

— Use of oral and written expression;

— Development of senses, use of body expression;

— Physical activity;

— Play and role playing.

ii. *At the primary level*

Health education should enable children gradually to:

— understand the main stages of human development (including body changes and sexual development);

— acquire knowledge of the body functions, growth and development (including the importance of personal hygiene and a balanced diet);

— acquire knowledge about environmental issues;

— know how to use the environment safely and cope in an emergency;

— acquire awareness about one's abilities, learning capabilities and responsibilities with a view to acquiring self-esteem;

— establish and develop relationships within and outside the school and to distinguish socially acceptable and unacceptable behaviour;

— acquire the ability to make use of leisure time;

— experiment with independence, taking account of others;

— learn how to make correct choices by assessing the risks for oneself and for others and accepting possible constraints;

— be capable of coping with emotions and feelings.

Methodology

— Building up a relevant body of knowledge and information;

— Teaching to observe and to use research methods;

— Enlarging fields of experience to develop capacities of reflection, analysis, clarification of values;

— Role playing, discussion groups, simulating situations.

iii. *At the secondary level*

Health education should enable adolescents gradually to:

— understand the major functions of the stages of life and the emotional and social development accompanying physical change;

— learn the importance of body management in relation to physical, mental and social health;

— appreciate the extent of the risks each individual can take;

— acquire knowledge about community health issues, prevention and health services;

— acquire knowledge about environmental health issues;

— become aware of their own possibilities, skills, intellectual capacities and learn how to exploit them;

— learn to analyse attitudes and behaviour which have an effect on health, with a view to helping towards appropriate decision-taking;

— learn how to put a positive value on their experiences during a period of important physical and emotional change and attain a proper measure of self-respect;

— acquire decision-making skills by developing their critical faculties in relation to the social environment;

— extend the area of their social experiences and to appreciate the dynamics of peer groups;

— progress in experiments of independence.

Methodology

— Building up a relevant body of knowledge and information through research;

— Developing the capacities to observe, analyse and criticise through self-evaluation and to sharpen decision-making skills;

— Exercising consistency between knowledge and action;

— Applying criteria to assess one's own equilibrium (physical, mental, social) within the environment;

— Discussion groups, role playing, guidance by older pupils, self-training.

3. Guidelines for the planning and development of a health education programme[1]

3.1. Educational systems, school curricula, socio-cultural backgrounds vary greatly in European countries and sometimes even within countries. Accordingly, at European level, only general guidelines can be given on the methodology to be adopted when planning and developing a health education programme. Health education programmes should, in any case, take account of school children's social and cultural background.

3.2. *The state of health and needs of children and young adolescents*

The state of health and needs of a school population can be regarded from a number of points of view. Physical aspects are certainly of importance and surveys may be carried out to this effect by the school health services. Social and behavioural aspects are more difficult to identify but crucial for the setting up of a school health education programme. Community services should be enlisted to co-operate in the assessment of the background "quality of life" of the community. The identification of health-related behaviour of the school population and their families is essential since, as shown by numerous studies, attitudes, values and even behaviour on a large number of health issues have already been acquired by the early age of 8.

The identification of the state of health and needs of the community should be carried out at regular intervals with a view to adapting the school health education programme accordingly. Once the planning process has been launched, this identification becomes in fact part of the evaluation scheme.

Once the state of health and needs of the school population have been identified, health education planners should, within a participative process, decide on a strategy and agree on priorities and objectives.

3.3. *The school health education programme*

This can be regarded as having three components:

— the health-promoting curriculum, including an overt "taught" component and a "hidden" component, incorporated into all aspects of the curriculum;

1. The various steps of the planning process have been described in detail in the Council of Europe publication, *Education for health: Preventing dependence and addiction*, Strasbourg, 1984.

— the ethos of the school or the "healthful school day";

— the various provisions of the school health and social services.

3.3.1. *The health-promoting curriculum*

The curriculum can be regarded as having two aspects: one consisting of courses which are taught in a way similar to other subjects, the other, less obvious, incorporated into other aspects of the curriculum and consisting of different approaches.

Education for health must include both the development of relevant knowledge and understanding and the opportunity to develop and practise a wide range of skills. In addition, however, it is deeply involved in attitudes, values, emotions and morality, all of which make demands on the teachers and the school organisation.

The health curriculum which has to be taught may well include distinct health modules, or projects. On the other hand, much that is best in health education is more concerned with the integration of good health teaching in other parts of the curriculum.

Table II (see appendix) suggests how broad themes of health — safety, food, relationships, substances, leisure and exercise, health and personal care — might be undertaken in a planned curriculum.

The contents of the above-mentioned table are in no way prescriptive or exhaustive. On the contrary, they are general and illustrative and each school should give emphasis to those aspects which are particularly relevant to its own circumstances. The table also seeks to demonstrate how issues might be raised throughout the career of school pupils.

3.3.2. *The "healthful school day"*

The ethos of any school will affect the health of all the people in it. Important in this respect is a whole range of issues too numerous to name. However, some obvious examples may be listed:

— relationships (principal/teacher, teacher/pupil, pupil/pupil, ancillary staff/pupil, etc.);

— physical condition of the building;

— conditions of the school environment;

— nature and quality of school meals;

— the effect of the teachers' behaviour, practices and life-styles on the pupils, etc.;

— the provision of opportunities for physical or leisure activities, not only through physical education but also during "breaks" in the school day.

If a school hopes to promote health, it must ensure that life within school is consistent with the aims of the health education programme; it should ensure physical and mental health and good social relations. If the school days are not healthy in terms of the psychosocial well-being of the pupil, there may well be reactions which, in the long term, carry serious health risks. It behoves those concerned with the health of young people to be aware of curriculum development and to demonstrate that the formal curriculum of the school is critically involved in the physical, mental and social conditions of all pupils.

In this context, as a greater proportion of children stay on longer at school, it is as well to remind all concerned that, in relying virtually entirely on performance in the external examination system as the sole means of selection for entrance to university, they force schools to devote increasing amounts of time to academic subjects with an inversely proportional amount of time being made available to social and health education. Thus, the humiliating effect of loss of esteem through poor performance in examinations is less exacerbated by the perverse but concomitant effect of having time available for social, health and moral education. Current changes in curriculum design should be aimed at improving the life-style of the pupil so that self-esteem will be enhanced.

3.3.3. *School health and social services*

Throughout Europe, school health and social services have developed to meet a need to tackle ill health among children. Teams have been appointed in schools to supervise the growth of pupils, sanitary conditions and the detection of disease. Such teams include a variety of skilled professionals, for example nurses, doctors, dentists, psychologists, social workers. Such services have undoubtedly contributed to the improvement in the health of children and young people in general which may be observed at the present time.

The traditional clinical tasks of these professionals have, however, largely become redundant and there is general agreement that their role should change accordingly and that they should, in particular, be encouraged to play a highly significant role in the life of the school community. The current, more holistic approach to education requires a

broad understanding of child development, the educational environment, the child's response to schooling, the disorders which interfere with a child's capacity to learn and the special needs of the handicapped. Well-developed lines of communication between health and social services and teachers have to be developed in order to understand the various influences of the family and the social environment on children. The change envisaged is more one of emphasis where the school health and social service will see its function much more closely linked with the educational process of the school.

The new tasks carried out by these staff may consist in:

— shifting emphasis from the preventive field to the promotion of health within the school and the community;

— offering advice to schools, and especially their teachers, on the health aspects of education and participating in the drawing up of the programmes as well as in their implementation;

— contributing towards increasing the teachers' knowledge of health-related issues (in-service training of teachers);

— promoting health education knowledge and practice among parents and in the community where the school is situated;

— assessing comprehensively, in association with the teacher concerned, the physical, social and emotional health of pupils and ensuring an appropriate follow-up.

Professionals of the health and social services are usually not trained to assume educational roles and it is not suggested that they should devote a large proportion of their time to direct teaching of children and adolescents, although their expert intervention may occasionally be most valuable in:

— carrying out epidemiological research on morbidity and psychosocial disorders with a view to identifying the needs of the school population (see above);

— contributing to the integration of children suffering from chronic diseases or handicap;

— controlling physical fitness for taking part in sports.

3.4. *A developmental approach*

Children, adolescents and the environment in which they live are continually changing; health education programmes should take account of these changes and developments.

Table I (see appendix) seeks to summarise a number of changes which occur in the lives of children and adolescents. It does not attempt to be all-embracing but simply to offer guidance on the issues which ought to be considered when a curriculum is being planned.

3.5. *Spiral curriculum*

The idea of repeated renewal, refreshment of issues, completion of knowledge and deepening of questions is important in what is referred to as a "spiral curriculum". Time and again, topics must be raised to match the needs of children as they grow older. This should be done with care, in such a way that teaching does not become repetitive, leading to lack of interest and boredom.

The above-mentioned table is presented in tabular form for the sake of clarity. As it is read, there is a need at each stage to consider not only the cognitive aspects of issues but also the range of life-skills necessary to solve real situations. Two examples may illustrate the point:

— Team games — 11 to 13-year-olds

With children of this age, demonstrating considerable variation in psychological development, the teacher might consider the following as they relate to the class:

- coping with shyness and feelings of inadequacy,
- coping with losing and winning,
- how to take the first step in a new sport,
- how to look for more attractive alternatives, etc.

— Role of substance abuse (licit or illicit) in adolescent life-style

Teachers might consider the following:

- the importance of teaching self-assertion,
- the role of peer pressure,
- how to cope with advertising,
- how to acquire self-confidence,
- how to find alternative solutions other than using substances.

3.6. *Strategies and methods of teaching*

Since health education is concerned with attitudes, values, emotions and behaviour as well as with more rational or cognitive processes, the teaching methods used must be appropriate to all aspects of it. A variety of methods need to be employed. Whilst it is probable that,

at present, few teachers will be competent in all methods, it is also probable that, among all the teachers in a school, expertise will exist in a great variety of techniques. Whatever methods are adopted, their effectiveness is influenced by the involvement and degree of commitment of the teacher.

Without knowledge, there will be no understanding and since health education seeks to promote decision-making, cognitive aspects should be taught using appropriate methods. Those commonly used in biology, home economics and social studies will be suitable. However, knowledge and understanding by themselves are not enough and beliefs, attitudes and values have to be clarified. Teachers, used to working in the humanities, in the field of language and literature, in media-related subjects, the arts, etc., may well have skills more appropriate to the affective domain. In general, participation by pupils in the learning process is important; methods which facilitate this participation are most likely to be useful. The following are offered as examples of methods which might be worth considering:

i. *Discussion*

There are many ways of stimulating discussion: through pictures, reports, accounts of personal experiences, etc. The teacher's role is one of facilitating discussion, creating an atmosphere in which questions are raised and explored. Teachers should try to anticipate questions and be prepared to answer them directly if asked. Since language is not only a means of communication but also a tool used to organise thoughts, it is important that young people explore health issues through group discussion.

ii. *Role-playing*

This can be useful in tackling emotional issues. Role-playing may come easily to some children but only with difficulty to others. When teachers are thoroughly trained to use this method, it can be very effective.

iii. *Scientific methods*

Observation, recording, experiment, use of statistics, etc.

iv. *Taking advantage of special events*

These might be current events reported by journalists, social events, religious ceremonies.

v. *Exploration/adventure*

It is good to be positive, seeking to promote enjoyment, excitement and interesting life experiences.

vi. *Demonstration*

This may be important in safety education, where it is followed by practice, repetition and conditioning.

4. **Research and evaluation**

Research should be focused on teacher training both at pre-service and in-service levels so that better teacher-training strategies, methods and materials can be developed.

It is important for the curriculum to take account of the current state of children's knowledge, attitudes and behaviour. Research should allow for a better understanding of the perceptions of pupils, teachers, parents, social services and health service staff and representatives of the community with regard to health. Thus, there is a need to conduct basic research regularly and systematically. This could develop into a system of monitoring change over a period of time.

There is also a need to assess the curricula in schools to ensure that, in general, they reflect the philosophy of education for health. In a similar way, it is the responsibility of individual schools to assess the state of their own curriculum in this regard.

Related to these forms of assessment, there should be a process of evaluation whereby a measure of effectiveness can be obtained. Essentially, there are three aspects to this evaluation process:

— a professional assessment of the stated proposals for a school programme;

— a description of the processes taking place in implementing the programme;

— an assessment of pupils and the surrounding community's reactions to the programme developed by the school staff.

5. **Training of teachers**

5.1. *Expectations put on teachers involved in health education*

The first expectation should be that teachers should promote healthy life-styles in the school and among the school population.

Coherence between content (taught curriculum) and the school's atmosphere and ethos (hidden curriculum) is crucial in this respect. At all stages of school life, the teacher should be expected to be able to establish the relationship between a given situation or activity and health. To do so, the teacher should be conscious of his/her behaviour and exemplary role, have some basic knowledge of the main relevant issues and, most important, possess the necessary skills to integrate his/her teaching into the whole curriculum. The teacher should also be aware of the relativity of his/her advice and counselling and of the need for updating his/her knowledge. He/she should be expected to know how to work in a multidisciplinary team (for example in co-operation with the school health services, parents, community leaders). He/she should also be able to contribute to any possible epidemiological work of school health staff.

The contents of the previous parts of this memorandum suggest that teachers might well accept responsibility for health education and be confident that, whatever their basic training, they can adapt and become competent in this field. Whilst in no way contradicting that premise, it must be recognised that being involved in education for health does cause concern to a certain proportion of teachers.

— Many feel that their own knowledge is inadequate.

— Many are unequipped to cope with working on issues which have important emotional, value-laden or moral components.

— Some teachers fear that their private lives may be called into question.

— Some feel that health education is the responsibility of others, for example parents or "health" professionals.

— Some feel that the school curriculum is already overloaded and that, professionally, they have little time to devote to acquiring knowledge or skills in a "new" subject.

The above shows that teachers need to be prepared for working in this field and, throughout Europe, there is an obvious need for the improved training of teachers in health education.

In surveying the state of preparation of teachers in European countries, certain broad generalisations emerge. Many nursery and primary school teachers receive some training which relates to health but, because of the context, they may not even realise that this is so.

— Part of this may emerge in the context of educational psychology and child development.

— Part may be related to issues concerned with the socialisation of children, for example hygiene, safety education, etc.

— Part may be biologically orientated, study of the body, nutrition, etc.

There is, however, disparity among countries and within individual countries regarding the training of these teachers in health education. No country seems to have a satisfactory system for providing health education in the professional preparation of teachers of young children, although one or two are seeking to remedy the position. It is strongly recommended that all countries should tackle the situation systematically.

The position with the training of secondary school teachers has some similarities but also differences.

— It is probable that an even smaller proportion of secondary school teachers have training in health education.

— Again, the provision of training is uneven.

— Apart from a few countries which have introduced specific teacher training courses in health education, most European countries rely on their teachers of biology, home economics and physical education to bear the brunt of formal health education. This means that they rely on the teachers to adapt their basic expertise to the new demands of health education, often without help. As a result, the cognitive aspects of health education are emphasised more than the important non-cognitive (affective) areas.

— Preparation in affective areas is weak.

— Consideration of teaching methods is frequently absent and, of course, this is particularly true again in the affective area. It should be recalled that the skills necessary for teaching health probably exist among the teachers in a school. Through team work and collaboration they could be shared.

To summarise, the position in most countries is still unsatisfactory. The objective is to identify ways of improving it.

Different countries will be able to identify their own special needs and should take early steps to do so. Each must consider carefully how to make the best use of its national resources for training. Options present themselves too in the form of "target groups". Some countries may give priority to improving the basic pre-service training of students in colleges and universities. Inevitably, it will be a long time before the

undoubted benefits of this strategy are felt. Others might bias their effort towards the in-service training of existing teachers. This latter approach has attractions because in most countries there are fewer new entrants to the teaching profession because of falling rolls. Furthermore, experienced teachers may better appreciate the totality of the concept of health as it affects pupils.

Four additional essential reasons are put forward as to the need for in-service training:

— the time which could be devoted to the general basic training in health education of student teachers is in any case limited; in-service training is necessary in order to complete basic training and to introduce a developmental approach in health education;

— in-service training is essential to enlist the co-operation of senior teachers (including head teachers) who have received no such training;

— only by means of in-service training is it possible to create a positive, receptive atmosphere in schools in conformity with health education messages;

— since most health education activities rely on multidisciplinary team work, the in-service training should also concern other personnel (school health staff, for example).

In theory, at any rate, there is no reason why both basic pre-service and in-service training should not be carried out simultaneously as much for the primary school as for the secondary school. Resources of money and expertise may be short and this may force policy-makers into clarifying priorities.

5.2. *Primary school*

Role of health education

Health education has a major role in primary school because it offers an opportunity to develop attitudes in children when they are very young and when the various issues are not yet felt by the children as being problematic. In addition, health education has to permeate all areas of school life, that is its physical, intellectual and social aspects.

Role of teachers[1]

As far as primary school teachers are concerned, it is recommended that all teachers should receive basic training since they have the overall responsibility of a class.

1. The special role of the school co-ordinator is described in item 8.6.

5.3. *Secondary school*

Role of health education

In principle, the philosophy of health education is no different in secondary schools to that in primary. Clearly, however, there are different logistic and methodological issues to be considered.

In secondary schools, academic issues assume greater importance and put pressure on the curriculum. The secondary school population is an adolescent one and, biologically/developmentally, adolescence is a complicated time. Health education is necessary to help young people cope with the problems of adolescence and to deal with the issues which they might have to face during this period. From this angle, in a secondary school there is a kind of inevitability and urgency for a planned programme of health education. Another important reason for the need to develop a programme is identified in the preparation for adult life. Adolescents should be given the opportunity to learn and relearn decision-making skills essential in their post-school years.

Health education is required by all young people regardless of cultural background. Life presents challenges and problems for all, not only for special groups, and therefore it is essential that every student be given the benefit of a programme of health education appropriate to his/her particular needs.

Despite the recognition that schools are expected to pass on the best values of society's heritage, they should not be concerned with forcing young people to accept them. Furthermore, values change and health education ought to be concerned with enabling young people to make choices which are the best for them. In this respect, the philosophy is the same as that of the primary school sector.

Role of teachers[1]

With the diversity of the subject-based secondary school curriculum, the question of the role of all teachers needs to be identified.

It is generally agreed that all teachers have a role to play, possibly quite minor in some cases, and that in their training they all ought to have at least some exposure to health education so as to be sensitive to the issues. Due to the pressure on the teacher-training curriculum, such sensitivity training might be very short — amounting realistically to, perhaps, no more than a couple of days (in terms of hours). All teachers should participate together with the school health and social staff.

1. The special role of the school co-ordinator is described in item 8.6.

Moreover, since all schools require a taught curriculum, some teachers ought to be prepared to do this. While differences in emphasis can be detected in different countries, there is agreement that certain disciplines, namely biology, physical education and home economics, are inevitably close to the whole range of health issues and it would therefore be both realistic and likely to be effective if teachers of these disciplines received extra training in health education. In a certain number of countries, significant progress has already been made.

One matter of concern is that the above subject areas have traditionally been concerned with factual and practical aspects, and less with the affective domain. It would behove those working in the field of teacher training to redress the balance in order to introduce this aspect into the special training of teachers in health education.

6. **Professional preparation in health education**

The contents and objectives of training, as described in the recommendation, should be built into the following four basic steps:

i. Personal education, that is, building up knowledge which, concerning health education, would be: the broad concept of health, an analysis of the factors influencing health positively or negatively, the history of disease, the importance of life-styles, the school as a health-promoting institution, the role of health education in the school, its importance for the development of the personality and personal skills, trends in health education, its place in the school curriculum, the fundamental aspects of the physical, psychological, mental and social development of children, etc. In all these areas, the objective is, *inter alia*, to stimulate reflection and analysis by the student-teacher on his/her own attitudes, values and beliefs.

ii. Professional expertise, that is, building up the didactic skills of future teachers. It seems essential that teachers should be trained in the specific active methods relevant to health education (questioning, analysing, classifying attitudes, values, preparing for decision-making and, finally, evaluating results) and to the principles of curriculum development (spiral development, selection of objectives, levels of appropriateness, identification of priorities, etc.).

iii. Practical training, that is, being given the opportunity to have some school practice. In this field, very little seems to have been done for health education, although the concrete example of senior teachers is very stimulating for student teachers, given the challenge of this particular subject.

iv. Training in the use of extra-curricular activities: since many of the health-related activities take place outside school (nutrition, sports, safety, drugs, etc.), it is important for student teachers to learn to appreciate their extent and influence, and seek ways of integrating such questions into the school curriculum in a meaningful way and of co-ordinating school health-education activities with family and community life.

7. **Organisation of teacher training**

7.1. *Organisation of basic teacher training*

In the absence of specialists for training student teachers in health education, the best short-term solution is probably to create within the normal training colleges a multidisciplinary training team composed, for example, of tutors, epidemiologists, doctors, nurses, psychologists, school authorities, sociologists, etc. In the long term, of course, it is hoped that an adequate number of specialist trainers will be available. A co-ordinator within the multidisciplinary team is an essential figure for the planning of a balanced multi-faceted teacher-training programme. While most of the above specialists come from outside the training establishment, the co-ordinator should belong to it.

7.2. *Organisation of in-service training*

Experience in member states shows that, for essentially economic reasons (schools are sometimes financed by the local community), adequate in-service training outside the school is difficult to implement. In some countries, it has been possible to reserve a small part of the regular time for in-service training of teachers to health education; this, however, amounted in general to no more than two school days/year. Under these circumstances, it is strongly recommended that in-service training be organised in the schools. A crucial preliminary step for the success of this procedure is to make the school head teacher aware of the issue through personal contact. His attitude will not only determine whether or not in-service training is going to be organised, but also the attitude of the teachers and their future involvement in health education activities.

7.3. *Guidelines for teacher training*

Bearing in mind that the educational process has several identifiable components — the hidden curriculum (in the ethos of the school), the informal curriculum (clubs, sports teams, the school environment)

and the formal curriculum which, together with the idea of the "healthful school day", form the totality of the school climate — teacher training courses should consider practical ways in which schools can become health-promoting communities.

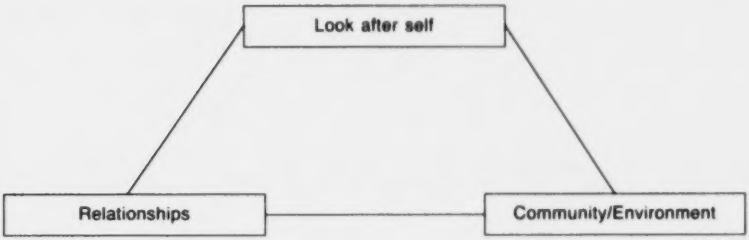
It is suggested that both the health and the educational sectors should co-operate, the former by producing material and guidance, the second by providing the staff and financing the courses. The basic approach of in-service training should be the same as in basic training: the first step being theoretical (knowledge), the second practical (methodology, case studies, etc.). There is a greater need, however, to prepare courses carefully so that they correspond to the teachers' expectations and concrete needs. Educational material should be as simple to use as possible in order to reduce the amount of effort to be made by teachers.

The present and future health needs of children can best be clarified through a human growth and development perspective. More importantly, training needs to consider the developmental stages through which children grow and the health issues associated with them (see diagram below and the appended Tables I and II).

Age	Development characteristics Physical, social, psychological, etc.	Needs Health issues	Implications for Teacher / School
0-4 years			
5-8 years			
9-13 years			
13-16 years			

For training to be successful, it must embrace a model of health education which is appealing to teachers and relevant to the teaching situation. It must also fit in easily with educational objectives and be clear and relatively simple to operate.

A three corner-stone model as follows is a useful model to this end:



All health education topics can be easily fitted into this three corner-stone model. The three corner-stones represent the central concerns of health education as follows:

Looking after self

Health education (like education itself) is concerned with helping children and adolescents make informed choices and decisions related to their health, behaviour and life-styles. This must of course be related to what is relevant and appropriate to the expectations of children and adolescents of different ages.

Relationships

Human relationships are probably the most important aspect of the human condition and should receive adequate attention at every level of schooling. Relationships of one kind or another permeate our daily lives and it is fitting that they should be part of a programme of school health education because of their influence upon our emotional, social and physical health.

Community/Environment

This aspect of health education is an extension of "relationships" into the human, physical and natural environment. It is vitally important that children are initiated into the importance of being part of a human community and the responsibilities and advantages which accrue. It is also vitally important to be able to demonstrate to children the way in which health is affected by our environment and ways in which it can be improved and conserved.

Taking into consideration that the personal beliefs, state of knowledge as well as the state of consciousness of the teacher influence his/her teaching and that all teachers teach values consciously or unconsciously, a major part of teacher training for health education should be concerned with the process of clarifying the teachers' own values and beliefs about health.

The methods used need to take into consideration:

a. the purposes and goal of the activity;

b. raising awareness of the "issue";

c. the process by which new information is given and assimilated;

d. interpersonalisation and resolution of the "issue".

7.4. *In-service training for topical questions*

Many health education boards or health ministries are faced with problems of sudden demands from teachers and public opinion to issue guidance for schools on some emerging issues brought into the limelight, essentially by the mass media. Behind this demand lies the expectation that, through the intervention of either health or health education authorities and the school, the problem may be alleviated.

While not denying the legitimacy of the demand by teachers for factual scientific information and possibly short in-service training, it is recommended that public opinion should not be made to believe that such short-term intervention would have a major impact, since health education is essentially a long-term process.

8. Policy-making in health education

Every child deserves the benefit of schooling where education for health is an integral part of school life. In exceptional circumstances, individual teachers and schools can be very successful in providing this; however, the impact of such efforts on the population as a whole is insignificant. Thus, national policies should be developed in such a way that resources of people and money can be made available for the spread of health education. A number of organisations, groups and individuals can be identified as having key roles to play.

8.1. *Government ministries*

There is a good case for close co-operation, at all levels, between the health and education sectors supporting the introduction of health education in schools. The policy-makers would have to take account of the logistic support needed to implement the policy.

8.2. *Regional co-ordinating committees*

Each administrative region should set up a committee representing the wide range of interests in health education such as education, environmental sciences, health, social services, parents, the Church, etc. It should include a senior teacher who is a generalist — head teacher or assistant head — otherwise the broad issues of the health-promotion at school may be lost in the thinking of subject specialists. Such a committee should adapt national policy to local needs and provide guidance to those working in the region. It is suggested that the regional committee be established in the context of a living educational environment such as a college of education, for it is important that health education be seen as an integral part of general education.

8.3. *Regional link person*

Each region would benefit from the services of an individual identified as having expertise in the field, who could carry out such functions as managing curricular developments, advising schools, acting as a consultant to teachers, organising in-service education. Again, the co-ordinator needs to be situated in an environment where he/she has strong links with others working in education.

Regional authorities might consider the advantages and disadvantages of fixed-term secondment as opposed to the permanent appointment of a co-ordinator.

8.4. *Head teacher*

Obviously, crucial to the promotion and development of health education in a school is its principal. Strong liaison and co-operation is needed between the regional co-ordinator and the head teacher and senior teachers in the school. It is also recommended that head teachers be brought together from time to time by the regional co-ordinator to discuss health education.

8.5. *School health education committee*

On a local scale, representation in this committee should correspond to the one suggested for the regional co-ordinating committee; it should include for example, the head teacher, teachers, staff of the school health and social services, parents, pupils (especially important in secondary schools), community leaders, opinion-makers, "significant others", etc. The task of such a body should consist in developing the

general lines of a transcurricular school health-education programme in the light of local needs. Within this body, a smaller "task force" should be entrusted with the more operational activities under the responsibility of the school co-ordinator (see below).

8.6. *In-school co-ordinator*

Within each school, a senior teacher should, if necessary, be designated, with responsibility for this activity. Such a person should not only be interested in health education and prepared to become proficient in it, but he/she should also and essentially be concerned with curriculum development and the organisation of teaching throughout the school. Improved career prospects should be offered to such senior teachers.

The role of the co-ordinator should be to:

i. draw up an overall programme for health education and personal relationships in the school, in association with the school education-for-health team and health service advisers;

ii. examine the existing programme in the school with the team in order to eliminate unnecesary duplication and to look for gaps in subjects covered;

iii. devise ways of filling important gaps — perhaps by agreeing on changes in the curriculum within established subjects, or by introducing a specific course;

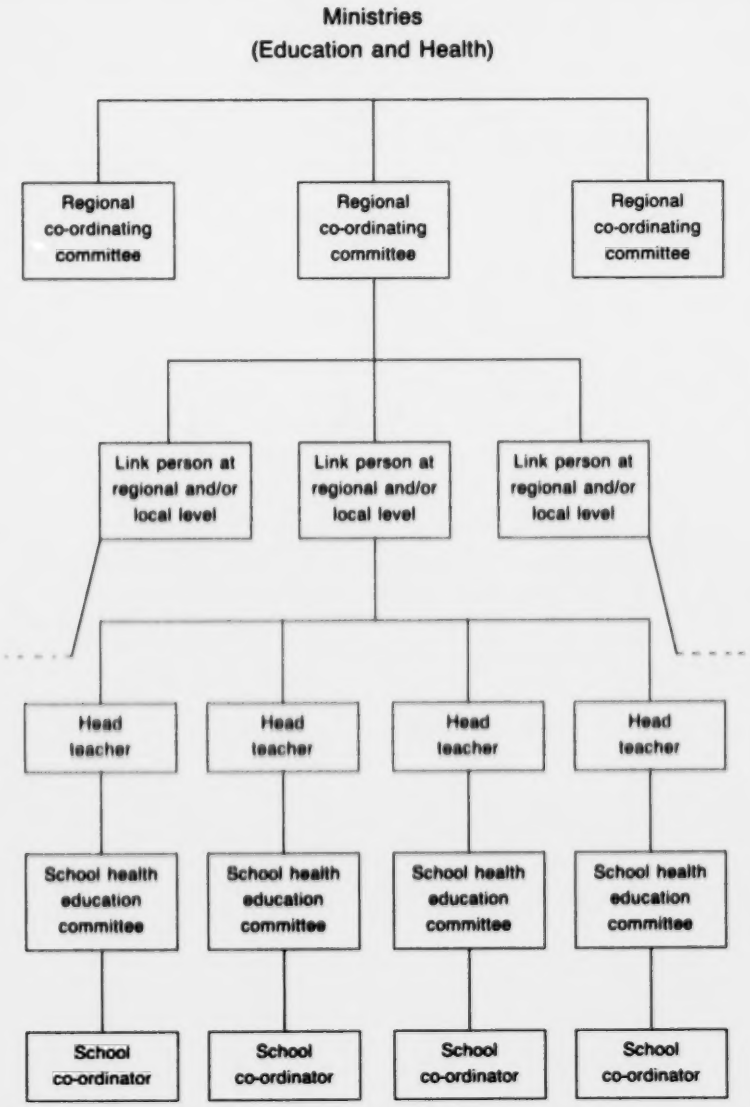
iv. take the leading role in organising any major new initiatives and to take a prominent part in the teaching programme;

v. act as a source of expertise for the staff as a whole, both by attending relevant courses and by passing on key information to colleagues;

vi. co-ordinate the evaluation of the course and initiate any necessary revision.

The organisation may be as shown in the following table (p. 35).

There are several levels of policy-making. In substance, it should provide broad guidelines and offer encouragement and support to individual teachers. Part of that encouragement can be demonstrated through the realistic provision of resources. In the end, the success of a health education programme in a school will depend on its relevance to local circumstances and the realistic provision of resources.


Ministries
(Education and Health)
Regional co-ordinating committee
Regional co-ordinating committee
Regional co-ordinating committee
Link person at regional and/or local level
Link person at regional and/or local level
Link person at regional and/or local level
Head teacher
Head teacher
Head teacher
Head teacher
School health education committee
School health education committee
School health education committee
School health education committee
School co-ordinator
School co-ordinator
School co-ordinator
School co-ordinator

8.7. *Resources*

Whilst it is recognised that education for health should permeate the whole curriculum and therefore largely rely on resources available in a variety of subject areas, it would be unrealistic to claim that there is no need for additional resources. In particular:

— time allocation must be made both for pupils and teachers;

— accommodation may need to be provided in certain cases to complement that of normal classrooms and rooms for practical work;

— materials need to be provided;

— co-ordinators need to be trained and remunerated.

Materials may be varied:

— in a number of countries, nationally packaged materials have been developed providing co-ordinated programmes;

— school systems need to consider the preparation of textbooks on health education or health components in non-specialist texts;

— an adequate supply of films, video and audio tapes, posters, publicity materials, etc. ought to be available for easy access to schools.

In another part of this report reference is made to "significant others". These are people who, in themselves, offer a resource of expertise which can support that available from teachers. They may also facilitate out-of-school activities, such as visits to places of interest, and enable schools to become involved in a variety of health-related services.

APPENDIX

Table I:

Developmental approach to health education

Age-group[1] (years)	Physical development	Social development		Mental and emotional development
		Skills	Relationships	
5-7	Slow growth of body Dental changes Possible exposure to infectious diseases Immunisation programmes Screening procedures for ill health and learning difficulties	Language skills Role modelling on parents and teacher New rules of eating, hygiene, etc., to be followed in school	Member of new community at school	Increased concept development including health Separation from home New relationships with teacher and pupils Psychological and social effects of screening Exploration of the environment
8-11	Steady growth — improved co-ordination of eye/hand, etc. Puberty: secondary sexual changes Menstruation (some girls)	Increased physical skills	Leisure pursuits New friendships: single sex groups	Continued openness towards the environment Emotional effects of sexual development

11-13	Puberty (affecting both boys and girls) Side effects of pubertal changes, for example effect on skin (acne) Possible change of school	Coping with sex roles Academic challenges	Importance of peers Challenging authority New relationships with teachers and peers	Body awareness Concern about body image Coping with a variety of new situations
13-16	Puberty continued (boys later than girls) Physical energy and strength Sexual development	Physical and social awkwardness to be overcome Risk-taking Entry into world of work (unemployment)	Changes in reference groups (for example peers, new adults) Challenges to family values Sexual relationships (real or imaginary) Health and occupational life, interaction between the individual and the world of work (hygiene, safety and psychosocial aspects)	Self identity Being accepted or rejected Emotional turmoil Value to society Expectations of future

1. The age-groups mentioned do not necessarily correspond to the subdivisions of national school systems.

Table II:

Broad theories for a health-promoting curriculum

Age-group (years)	Safety	Food	Relationships	Substances	Leisure and exercise	Health and personal care
5- 7	Home/fire safety Road safety School safety (for example, prepare for new settings, furniture, playground, etc.)	Food for nutrition Use of food in family situations	Sharing, giving and taking Family relationships Relationships with teachers Respect for others Tolerance (race, etc.)	Respect for all substances (for example, household, chemicals, medicines)	Play Range of activity Rest, relaxation, sleep	Hygiene Immunisation Dental care
8-11	Cycling, Road safety Play Aggression	Food choice/ experimenting with new foods	Groups of all kinds Puberty Menstruation Education about reproduction	Cigarette smoking Solvent abuse Alcohol	Physical exercise, game skills Place of team games Participation	Learning about the body (simple anatomy and physiology)

11-13	Safety in specific areas (for example, kitchen, school laboratories, workshops) Safety in hobbies	Consumer education, persuasive advertising Food hygiene Preparing food	Importance of peer groups, significant adults both within and outside the family	Above continued (perhaps with different emphases, for example, on social role of substance use) Cannabis	Team games Individual sports Role of physical exercise in keeping fit	Health care system Diseases
13-16	Care of environment Road Safety Motorcycle Workplace	Non-nutritional aspects of food : - social - psychological - slimming	Teenage relationships Need of esteem, love, affection, fulfilment Family planning	Alcohol Role of substance abuse in adolescent life-styles Society's views on substance abuse	Cardio-vascular fitness : aerobics, jogging, etc. Use of the environment	Health care system Disease prevention
16+	↓ Motor cycling Driving Workplace	↓ Family nutrition	Preparation for marriage Care of others : - young - handicapped - old Separation Bereavement	↓ (Above continued) Role of risk-taking in substance abuse Effect of abuse on relation-ships	Recreational and social use of exercise	Social services Preparation for independence

The "arrows" in the table indicate that issues would be continued with successive age-groups

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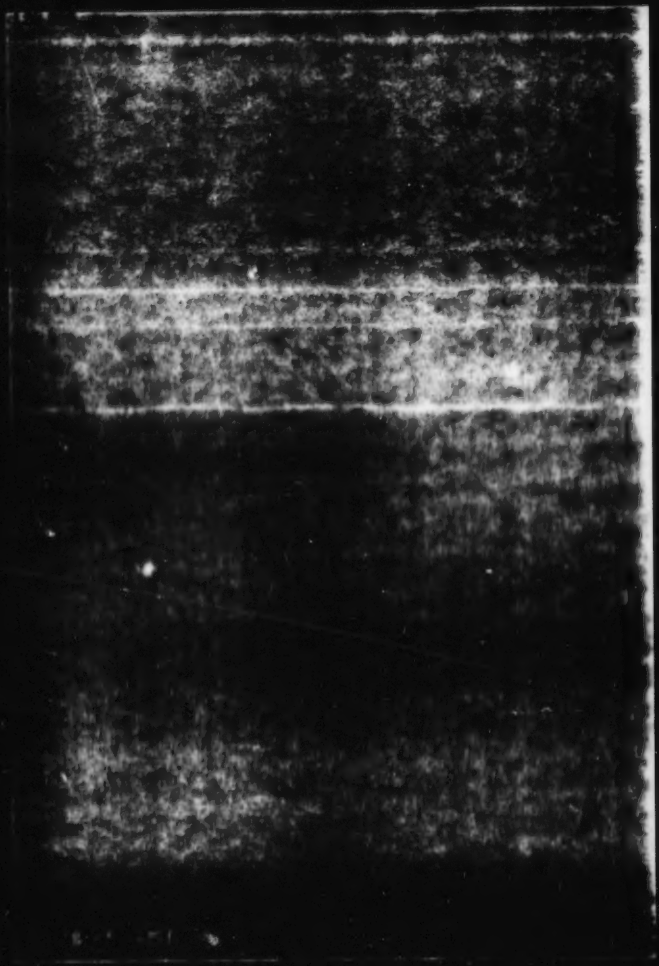

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